COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR

2.5 PARAMETERS FOR ASSESSMENT AND MANAGEMENT OF CLIENTS AT RISK FOR DANGER TO OTHERS

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I. INITIAL CONTACT

A. Screening

Upon first telephone or face-to-face contact, intake workers should make efforts to determine the urgency for clinical contact based upon the client's:

1. Level of emotional distress, (e.g., rage,)
2. Recent behavior, (e.g., current intoxication,)
3. Content of statements, (e.g., homicidal thoughts or thoughts of harming self, others or property,)
4. Nature of situation described, and
5. Nature of service request.

B. Transfer to a Clinician

1. Expression or description of violent thought, plans, statements or actions by a client or other informant should be immediately documented and referred to a designated clinician, (e.g., Officer of the Day.)

2. The person initially handling the contact in which information of potential dangerousness is disclosed should make every effort to get the exact name of the client or informant, telephone number, address, and current location before transferring management to a clinician. In instances where the client refuses to give identifying information, this should not delay transfer to a clinician.

C. Maintaining Safety

Reasonable precautions should exist for working with potentially violent individuals and should include:

1. Provision of ongoing training on elements of workplace safety, (e.g. weapon management, how to deal with an agitated or threatening client.)

2. Maintenance of a safe interviewing environment, (e.g., availability of alarms, exits and backup assistance, and absence of dangerous objects.)

D. Information Provided by an Informant

Statements by an informant about a client's recent or past history of potentially violent ideation, statements or behavior should always be documented and considered seriously in assessing risk even though the informant may be anonymous or may contradict the client's statements or be denied by the client

E. Initial Clinical

1. Screening for intent to harm self, others or property should be part of

Contact every initial clinical telephone or face-to-face contact.

2. When indicated by screening, the designated clinician should perform and document an emergency assessment in order to ascertain the presence of significant risk of danger to others and need for emergency management.

3. When the assessment of a caller indicates there is a high risk of immediate danger, another staff or supervisor should be alerted to contact the police while the clinician continues to engage the client by phone.

F. Employees Who Receive Threats Employees who receive threats should immediately follow their Department's Threat Management procedures, (e.g., for the Department of Mental Health, employees should notify the Safety Officer, or any member of the Crisis Management Team.)

II. EMERGENCY DANGER TO OTHERS RISK ASSESSMENT

A. Components The Emergency Danger to Others Risk Assessment should include:

1. The reason the client has contacted the agency or otherwise came to the agency's attention,
2. The specific nature of help the client, or person referring the client, desires (or refusal of help,)
3. The presence of specific external sources of stress, including job, school, relationship loss/changes, or victimization history such as recent humiliating life event, bullying, and/or recent sense of being treated unfairly,
4. The degree to which the client experiences frustration, and/or anger, and the presence of overt hostility,
5. Nature of violent thoughts, statements or plans,
6. Practicality, specificity and lethality of plans (including availability of weapons and specificity, identification and proximity of intended victim[s],)
7. Preoccupation with guns or other weapons,
8. Nature and timeframe of previous acts of violent behavior involving self, others or property, including the presence of a pattern of escalation of violent thoughts or behavior towards a specific individual or other people,
9. The presence of reasons for a client or informant to exaggerate or understate concerns about potential violence,

10. Evidence of other mental symptoms and disorders, especially those

involving paranoid delusions, violent command hallucinations, and other psychoses, antisocial, and borderline personality disorders, disorders of impulse control, conduct disorders, despondency, loss of self-esteem, alienation, agitation, and anger,

11. Evidence of substance-related pathology: intoxication, recent drug or alcohol use,
12. Negative reaction to suggested treatments,
13. Protective factors, (e.g. availability of a strong family support, parents/children/dependents,) and
14. Awareness of possible signs of antecedents of violence and or agitation that may signify impending risk.

B. Determination of Level of Risk

1. The emergency risk assessment should clearly document the clinician's assessment of the level of dangerousness described as Low, Moderate, or High.

2. The basis for determination, (e.g. history, behavioral observations, statements of the client or significant others.)

C. Emergency Risk Assessment Follow-Up

After an emergency risk assessment, the clinician may:

1. Cause the client to be taken into 5150 or 5585.55 custody,
2. Seek timely relevant consultations, including medication assessment,
3. Initiate a full clinical assessment,
4 Schedule the client for additional assessment and a follow up appointment, or
5. Refer the client to appropriate community resources.

D. Involvement of Others/ Safety Issues /Confidentiality

1. Significant others should be notified and engaged to provide support and limit access to potential weapons as clinically indicated and permitted by statutes, policies and procedures regarding confidentiality.

2. In the case of minors, parents/guardians should be notified and engaged to limit access to potential weapons and provide an appropriate level of supervision, support, and guidance in problem solving and conflict resolution.

3. When consent is not possible and a client is at risk of committing violent acts, the clinician should limit the disclosure of confidential information to only that which is necessary to obtain emergency intervention in order to save life.

4. Other agencies, (e.g., law enforcement, public health,) and intended victims should be notified depending on the nature and acuteness of risks

to others. Tarasoff warnings must be made as required by Law.

III. COMPREHENSIVE DANGER TO OTHERS RISK ASSESSMENT

A. Indications

1. A comprehensive assessment should be completed for clients:

   a. Who have recently made threats or attempted violence towards others,
   b. Express or admit to violent thoughts and or intentions,
   c. Who demonstrate threatening behavior, or
   d. When a third party has indicated the possibility of violent behavior.

2. Comprehensive clinical assessment for clients believed at risk for potentially violent behavior should be expeditiously initiated, and should be regularly evaluated for as long as clinically indicated.

B. Documentation

The comprehensive assessment should be completely documented in the medical record, and danger to others-related components of the assessment should be easily found and prominently noted when significant risk is present.

C. Components

1. Comprehensive assessment should at minimum include the complete evaluation for mental disorders and acute stressors performed at the agency in which the client has sought and been offered services.

2. The comprehensive assessment should specifically include known factors that affect risk of committing violence, including:

   a. Factors 1-14 in the emergency risk assessment, (Section II. A)
   b. Compliance with suggested interventions (including medication compliance) since the emergency assessment,
   c. Any changes in the client's situation or actions by the client since the emergency assessment.

D. Assessment of Lethality

Assessment should include, to the extent possible, factors in the client's physical and psychosocial environment that may increase the risk of violent behavior, (e.g., presence of weapons, or loss of job or significant others.)

E. Assessment Summary

The assessment should clearly document the estimated degree of risk of danger to others present, stated as Low, Moderate or High risk and the basis for determination, (e.g. history, behavioral observations, statements.)

F. Treatment Plan Documentation

The treatment plan derived from the assessment should document the manner in which the estimation was derived, the manner in which the degree of risk of danger to others has influenced the treatment plan, and any specific measures taken to decrease the risk of violence.

G. Measurement of Risk

Specific instruments to measure risk of danger to others (e.g., the HCR-20 [Historical, Clinical Risk Management Scale],) if used, should be interpreted by qualified clinicians, and should only be used as an adjunct to competent clinical assessment. When the assessment of risk of danger to others differs from that of a previous assessment, the change should be explicitly noted, the reasons determined, and the manner in which the change affects treatment (or why treatment remains unchanged) should be documented.

H. Involvement of Others/ Confidentiality

1. Within the limits of confidentiality, significant others should be notified of assessed risk of danger to others and their help enlisted when clinically indicated.

2. Other agencies, (e.g., law enforcement, public health,) and intended victims should be notified depending on the nature and acuteness of risks to others. Tarasoff warnings must be made as required by Law.

IV. MANAGEMENT OF CLIENTS AT RISK FOR DANGER TO OTHERS

A. Reassessment

1. Clients at risk for potential violence should be regularly reassessed to determine changes in the degree of risk and treatment plans should be adjusted accordingly.

2. The client's environment should be continually reassessed to the extent practical to detect and mitigate risk factors, (e.g., guns.)

B. Involuntary Hospitalization

Involuntary hospitalization should be considered and, where appropriate, immediately implemented, for clients at high risk of danger to others.

C. Engagement of Support System

Within the limits of confidentiality, the client's support system should be kept apprised of the client's risk of danger to others, and their help should be enlisted whenever clinically appropriate.

D. Pharmacological Interventions

1. Short-term psychopharmacologic agents may be administered when the client is acting in a seriously threatening manner, towards self or others. Choice of medication includes rapid-acting antipsychotic, antianxiety and sedative medications that are likely to most quickly establish impulse control. Monitoring by staff for effects on respiration, blood pressure, pulse rate, and level of consciousness are imperative.

2. Long- term use of drugs to manage aggressive behavior should occur only as a component of a treatment plan that is based upon a comprehensive history, complete diagnosis, and consideration of a full range of psychological, social and environmental interventions. Prior treatment experience, substance abuse, and diagnostic precision should guide physicians regarding the appropriate medication.

E. Psychotherapeutic Interventions

Essential psychotherapeutic interventions for clients at risk of danger to others include:

1. Explorations of alternatives to violence as a viable option,
2. Strengthening social supports,
3. Increasing ability to cope with loss, change, the triggering situation,
4. Anger and stress management, and
5. Counseling for client and significant others regarding limitation of the availability of potential weapons to decrease potential for deadly impulsive actions.

F. Emergency Support System

Clients at risk of danger to others should be provided with a 24/7 method of establishing contact with mental health resources that can effectively intervene when necessary to decrease risk of danger to others.